Promoting Health and Behavioral Health Equity in California

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Behavioral health disparities are not usually considered part of the same system of health disparities. However, the California Department of Public Health focused its health equity strategies on reducing behavioral health disparities through its California Statewide Plan to Promote Health and Mental Health Equity. This statewide plan was developed through a community-wide stakeholder engagement and outreach process. In addition, the California Reducing Disparities Project is a prevention and early intervention effort to reduce mental health disparities in underserved populations. This strategic plan represents the voice of several racial/ethnic communities, such as African American, Asian and Pacific Islander, Latino, Native American, as well as lesbian, gay, bisexual, transgender, and queer and questioning communities in California, through 5 strategic planning workgroups. The workgroups were composed of a broad range of stakeholders, including community leaders, mental health care providers, consumer and family members, individuals with lived experience, and academia. This case example highlights the various efforts of California's Office of Health Equity in eliminating behavioral health disparities and promoting mental health equity, as well as discusses the unique statutory and regulatory role of the Office of Health Equity's deputy director.

KEY WORDS: California, health disparities, mental health, state offices of minority health

Mental and behavioral health disparities and inequities among racial and ethnic populations and lesbian, gay, bisexual, transgender, and queer and questioning (LGBTQ) communities present a significant health equity issue for the United States. For example, in California, rates of serious mental illness are higher than average among Native Americans, multiracial individuals, African Americans, and Latinos.[1] In addition, according to the President's New Freedom Commission on Mental Health, "The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them."[2]

Barriers to appropriate mental and behavioral health services include a lack of culturally and linguistically competent services, racism and discrimination from individuals and institutions, stigma regarding mental illness, lack of insurance coverage, underrepresentation in mental health research, and inaccurate diagnosis.[2] As a result, certain racial and ethnic populations are underserved or inappropriately served by the mental health system and bear a higher burden of disability from their mental health disorders. Eliminating these disparities and inequities should remain a goal of an improved mental and behavioral health system.

The California Department of Public Health (CDPH) focused its health equity strategies on reducing behavioral health disparities through its Office of Health Equity's (OHE's) priorities and activities, and stakeholders played a key role in OHE's development and priority-setting. These stakeholders helped OHE establish its vision for health equity, which is that everyone in California has equal opportunities for optimal health, mental health, and well-being and that success is predicated on improving the health conditions of California's most vulnerable populations as the state

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addresses the source of those conditions.[3] This case example highlights the administrative and policy levers that OHE uses to eliminate behavioral health disparities and promote behavioral health equity and also discusses OHE's deputy director's unique statutory and regulatory role.

Federal agencies have taken the lead in addressing mental and behavioral health disparities through initiatives such as the US Department of Health and Human Services' National Stakeholder Strategy to Achieve Health Equity[4] and the Action Plan to Reduce Racial and Ethnic Health Disparities.[5] The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Office of Behavioral Health Equity also works to reduce behavioral health disparities among minority racial and ethnic populations and LGBTQ communities using the following strategies:

- The *data strategy* ensures that SAMHSA surveillance and performance data guide program planning to address behavioral health disparities.
- The *communication strategy* promotes awareness and access to information about behavioral health disparities.
- The *policy strategy* addresses relevant disparity issues and behavioral health equity by targeting these issues in SAMHSA policy and funding initiatives.
- The *quality practice and workforce development strategy* creates and supports innovative, cost-effective trainings that contribute to a well-trained, high-quality, diverse workforce.
- The *customer service/technical assistance strategy* establishes the Office of Behavioral Health Equity as a trusted broker of disparity-related information and experts.[6]
- State public health agencies located within a larger agency often reside in that agency with other programs such as Medicaid, Medicare, and substance abuse and mental health services. The Association of State and Territorial Health Officials' (ASTHO) State Profile Survey revealed that 90% of states whose public health agencies are under a larger agency (n = 19-21) have responsibility for their states' mental health authority.[7] In addition, 21% of state health agencies provide population-based primary prevention services focused on mental illness whereas 30% provide prevention services focused on substance abuse (n = 47).[7] Behavioral health integration can improve care by using systematic coordination and collaboration within state health agencies to address both mental and physical health needs.

These overlaps in jurisdiction and authority indicate that state public health agencies have opportunities to integrate public health and mental health services within the public health approach to prevention and treatment. In addition, mental health and public health can work together to leverage state public health's accumulated experience in addressing social determinants of health, promoting prevention and early intervention, community and provider education, surveillance, screening, and electronic data systems and information exchange.[8] Public health agencies can incorporate mental and behavioral health issues into their strategies and plans, especially in partnership with public mental health agencies.

California's work through its Office of Health Equity (OHE) demonstrates that state offices of minority health can play an important role in behavioral health integration. State offices of minority health were originally established to reduce health disparities and improve the health of racial and ethnic minority populations and communities. As part of their core competencies, state offices of minority health traditionally monitor a community's health status, inform, educate, and empower people, mobilize community partnerships and action, and develop policies and plans to support health efforts.[9] However, they do not typically focus on behavioral health. Although data from ASTHO's 2014 Minority Health Survey show that 35.2% of respondents (n = 54) have behavioral health staff working on minority health, health disparities, and health equity initiatives in state and territorial health departments, there have not been many documented efforts to systematically and strategically improve statewide behavioral health disparities. In fact, California is the only state that has an OHE that specifically addresses disparities in both physical health and mental health. To ensure the viability of this unique commitment, California's OHE has been authorized to grant $60 million in state Mental Health Services Act (MHSA) funds over the next 4 years to identify, implement, and evaluate community-defined promising practices in reducing mental health disparities.

Background

California's OHE was established in 2012 through Section 131019.5 of the California Health and Safety Code.[10] Through OHE, the state consolidated the functions of 5 state-level offices and initiatives: Office of Multicultural Services, Office of Multicultural Health, Office of Women's Health, Health in All Policies (HiAP) Task Force, and Healthy Places Team. OHE's mission is to lead the charge to reduce health disparities in vulnerable communities in California.

Currently, OHE consists of 3 units: Community Development and Engagement, Policy, and Health Research and Statistics. The Community Development and Engagement Unit oversees the California Reducing

Disparities Project (CRDP). The Policy Unit staffs the HiAP Task Force, the Climate and Health Team, and the Healthy Places Team and works on cross-departmental and cross-agency projects on social determinants of health. The Health Research and Statistics Unit conducts research and produces data and reports to support OHE's mission.

OHE is led by a governor- or state public health officer–appointed deputy director who is also Senate-confirmed, a unique structure compared with other states' offices of health equity or minority health. OHE's deputy director reports directly to the state health official. According to ASTHO's 2014 Minority Health Survey, 26.4% (14/53) of the primary contacts for health equity issues (usually the directors of the state offices of minority health and health equity) also report to the chief state health official, but this reporting relationship has been codified through legislation in California.[11] This statutory requirement brings health equity issues to the attention of the most senior health agency management and allows OHE to take on a cross-cutting leadership role in the state health agency.

OHE is charged with the following goals and tasks:

- Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.
- Work collaboratively with the HiAP Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.
- Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.
- Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

OHE's duties include the following:

- Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities, which is updated every 2 years.
- Establishing an advisory committee.
- Establishing an interagency agreement between the state's Department of Public Health and Department of Health Care Services to outline the process by which the departments will jointly work to advance OHE's mission.
- Conducting demographic analyses on health and mental health disparities and equities, which are updated periodically.
- Building upon and informing the work of the HiAP Task Force.
- Assisting and consulting with state and local governments, health care and mental health care providers, community-based organizations and advocates, and various stakeholder communities.[10]

OHE Advisory Committee and the California Statewide Plan to Promote Health and Mental Health Equity

The California Statewide Plan to Promote Health and Mental Health Equity ("Statewide Plan") was developed through an Advisory Committee and community-wide stakeholder engagement and outreach process. While the OHE facilitated the process for creating this document, the outcome reflects the thoughtful participation of hundreds of stakeholders. Those who invested the most time were the 25 members of the OHE Advisory Committee, who worked alongside the public and OHE staff over the course of three 2-day meetings and for many hours before and between those meetings. These members were chosen from 112 applications received by CDPH, a sign of both the enthusiasm and expertise brought to bear on this endeavor.

The OHE Advisory Committee held its first meeting in September 2013. The group consists of representatives from state agencies and departments, local health departments, community-based organizations, and direct service providers. Members include advocates, consumers, providers, and experts in the areas of health equity, behavioral health, and mental health services. Per the state's Health and Safety Code section 131019.5, it is required to meet quarterly every year.

The Advisory Committee meetings held in January, March, and May 2014 were largely dedicated to providing input into the development of the Statewide Plan. At these meetings, there were presentations; full committee discussions; small group discussions involving Advisory Committee members, OHE staff, and the public; and formal public comments. Members of the public who were not able to participate on-site were able to participate via conference call.

In April and May 2014, statewide webinars were held to introduce initial drafts of the Statewide Plan, answer questions, receive comments, and allow for polling to establish priorities and partnership interests. A 61-item survey was also made available during that time for more in-depth feedback opportunities. The input from more than 120 survey respondents and several letters was considered in the further development of the Statewide Plan.

Engagement with the public consisted of hundreds of meet and greets in person and occurred by phone with OHE staff, primarily with the Deputy Director, Jahmal Miller. These meetings additionally informed the Statewide Plan.

The Statewide Plan emerged from the iterative work of the Advisory Committee and encompasses both health and mental health. The Advisory Committee members have been strong advocates for paying due attention to mental health in the Statewide Plan. The executive summary of the Statewide Plan states,

> Mental health is one aspect of overall health, and, as such, should be assumed within all references to "health." However, in recognition that mental health has historically been excluded—and in many circumstances continues to be excluded—from society's overall approach to health, it is called out explicitly throughout the Statewide Plan.[3]

The Statewide Plan is OHE's first biennial report on health and mental health disparities in the state and a road map for how to eliminate these disparities through cross-sector action. According to the Statewide Plan itself,

> [it] is intended to illuminate the scope of the health equity challenge with compelling data and narrative. It makes the case that health is a basic human right, that health inequity is a moral and financial issue, and that health equity is in everyone's best interest. It also provides a brief summary of the most pervasive social determinants of health, and it offers examples of programs, policies, and practices that have begun to make a difference in the state's most vulnerable communities.[3]

The Statewide Plan's 5-year strategic priorities are as follows:

1. Through assessment, yield knowledge of the problems and the possibilities.
2. Through communication, foster shared understanding.
3. Through infrastructure development, empower residents and their institutions to act effectively.[3]

Goals for each of the strategic priorities were crafted for California overall, as well as for the health field, among potential health partners, and within local communities for stage 1 (2015-2018) and stage 2 (2018-2020) of the Statewide Plan. As an inaugural effort, OHE also recognized the critical need to create goals aimed at building capacity for implementation of the strategic priorities. The Statewide Plan was informed in part by other state efforts to provide vision, coordination, resources, and accountability to the health and well-being of California's residents, including the California Wellness Plan, Let's Get Healthy California, and the CDPH Strategic Map. Thorough involvement of local health officers and community stakeholders in the strategy development of the Statewide Plan and its ongoing implementation also allows for bidirectional integration with community health improvement plans as feasible.

The Statewide Plan guides the *overarching* work of OHE, which includes CRDP (detailed later)—an initiative focused specifically on mental health that has undergone its own concurrent very extensive, community-driven planning process. Deputy Director Miller's role has been to set and communicate the vision for OHE, which includes the development and implementation of these plans with strong, respectful community and cross-sector involvement.

California Reducing Disparities Project

In response to former US Surgeon General David Satcher's call to national action to reduce mental health disparities, in 2009, a group composed of California's former Department of Mental Health, its Mental Health Services Oversight and Accountability Commission, the California Mental Health Directors Association, and the California Mental Health Planning Council created a statewide policy initiative to identify solutions for underserved communities.[12] This policy initiative, called the "California Reducing Disparities Project," focuses on 5 populations: African Americans, Asians and Pacific Islanders, Latinos, LGBT individuals, and Native Americans.

The CRDP vision is "service delivery defined by multicultural communities for multicultural communities" through identification of strategies developed across targeted communities to improve outcomes and reduce disparities; implementation of selected community-identified strategies; culturally and linguistically competent Community Participatory Evaluation of community-defined evidence for racial, ethnic, and cultural communities; and replication of approaches to reduce mental health disparities.

CRDP was placed within the purview of OHE to administer this policy initiative and was organized into 2 phases. To guide the project, phase I involved bringing together the CRDP partners, including the California Pan-Ethnic Health Network, the California MHSA Multicultural Coalition (CMMC), and 5 Strategic Planning Workgroups (SPWs), which represented each of the 5 targeted populations. The SPWs' diverse membership included mental health care providers, community leaders, consumer and family members, individuals with lived experience, and academic experts.

Through an intensive community-based participatory research process, the SPWs gathered information from their communities to inform the strategic plan. They used focus groups, interviews, and surveys to

involve community members in this in-depth examination into community needs, mental health services, and policy recommendations. The SPWs developed and identified community-based strategies and promising practices to change the public mental health system in California for each of the 5 minority populations. The resulting reports included recommendations for reducing mental health disparities and removing barriers to accessing programs and services, along with a list of promising practices defined by each community that could help reduce disparities. In addition, the SPWs shared the initial drafts with their communities for feedback. All of these reports are available on the CRDP Web site.[13]

CPEHN identified common themes and strategies among the 5 SPW reports and developed a draft of the CRDP Strategic Plan to Reduce Mental Health Disparities ("CRDP Strategic Plan"). Both CPEHN and OHE held town hall meetings throughout California and provided a 35-day public comment period to solicit community feedback on this draft CRDP Strategic Plan.[3] More than 800 comments were received and are currently being synthesized into the final CRDP Strategic Plan.

Developing cross-sectoral partnerships is both an OHE priority and required as part of the office's policy lever. OHE's work is informed by its Advisory Committee and stakeholder meetings. The office also consults with community-based organizations and local governmental agencies to make sure that community feedback and perspectives are included in strategic plans, recommendations, policies, and implementation. OHE also solicits community feedback and input through CMMC, which addresses a variety of mental health issues in California and integrates cultural and linguistic competence into the public mental health system. CMMC provides a new platform whereby different racial, ethnic, cultural, and LGBTQ communities can come together to collaboratively seek solutions that will eliminate barriers and mental health disparities.

Building on the strong community input and planning during phase I, phase II of CRDP will involve 4 years of funding totaling $60 million to implement and evaluate the strategies and recommendations from each SPW. OHE plans to fund selected approaches across the 5 CRDP-targeted populations with strong evaluation, technical assistance, and infrastructure support components. Each SPW population report provided a list of promising practices that represented the types of programs the community would like to see funded in phase II. As a result, phase II will focus on demonstrating the effectiveness of community-defined promising practices in reducing mental health disparities.

To this end, in March 2015, OHE released Draft Pre-Solicitations for the CRDP Statewide Evaluation Team, Technical Assistance Provider, Capacity Building Pilot Projects, and Implementation Pilot Projects. More than 200 comments from the public were received and are currently being synthesized into the development of the final solicitations.

All of the key activities within phase I and phase II are encompassed within the Statewide Plan. However, as discussed, the CRDP Strategic Plan was shaped through its own community-centered process and allows for a much greater level of detail specific to mental health equity and the needs of the 5 identified population groups.

Cross-cutting Work

Improving health and mental health equity requires addressing the social determinants of health, which impact where we live, work, and play. To make this happen, OHE works extensively with communities, community-based organizations, advisory groups and steering committees, and other stakeholders in a participatory process that guides OHE's work and output. OHE also collaborates on cross-agency initiatives, such as staffing the HiAP Task Force, the Climate and Public Health Team, and the Healthy Places Team, to improve the social determinants of health. The HiAP Task Force is housed under the Strategic Growth Council and brings together 22 state agencies and departments to work together to support a healthier and more sustainable California. The council is a cabinet-level committee that coordinates state agencies' activities to improve environmental health and natural resources, increase affordable housing, improve transportation, and work on community and economic development. The Climate and Public Health Team provides technical assistance and consultation on climate and health issues with a health equity lens and shares resources with federal partners and other state public health entities. The Healthy Places Team works on the Healthy Communities Data and Indicators Project, which provides data, a standardized set of statistical measures, and tools that diverse sectors can use to plan healthy communities and evaluate how plans, projects, policies, and environmental changes impact community health. The OHE Advisory Committee and stakeholders are regularly engaged in informing this cross-sectoral work. All of these activities are encompassed within the Statewide Plan.

Evaluation

OHE is in the early stages of evaluation but is considering using independent evaluators from local

research universities to assess how consumers use local mental health resources. Because of how challenging it is to evaluate cross-sectoral initiatives, OHE is carefully considering how to develop a robust evaluation component. This evaluation will incorporate a mixed-methods approach, and OHE will make sure that all methods, surveys, and focus groups are culturally and linguistically appropriate. OHE recently hired a Research Scientist Supervisor II to oversee its Health Research and Statistics Unit. This position will be responsible for tracking progress overall on the Statewide Plan and reporting that progress quarterly to the OHE Advisory Committee and the public. As of the writing of this case study, the Statewide Plan is on the verge of public release and the initiation of its first implementation stage.

As a special project within OHE, CRDP has its own evaluation component. In phase I, OHE considered the extent to which the SPWs engaged respective communities throughout the state; convened focus groups in rural, urban, and geographic regional areas; conducted key informant and cultural broker interviews to identify community strengths; developed community needs assessments; participated on mental health committees to educate, update, and garner input/feedback; and conducted community forums prior to, and after, dissemination of the reports. Approximately a quarter of the CRDP funds in phase II will be spent on evaluation, as a main impetus for the project is demonstrating the effectiveness of community-defined promising practices in reducing mental health disparities. Once CRDP has completed its 4-year cycle, it will share information on the project's impact, including the process, metrics, and data.

Lessons Learned and Recommendations

Although it is still a relatively new office, OHE has already used several policy and administrative levers in its work to improve health and behavioral health equity in California. Recommendations and lessons learned from its process include the following:

- *Do business differently*. Doing business differently involves attentive listening and genuine attention to community and partner input in order to be responsive to community needs. As OHE implements CRDP phase II, it is mindful of the following key values:
  - Build community capacity.
  - Keep fairness at the forefront.
  - Continue to move to systems change.
- *Use community-driven action*. The CRDP Strategic Plan is community-driven and community-authored. To do this successfully, it is necessary to build in time at the front end of the process. It is critical for the community to vet the document at each step and at every change, so it may take longer to actually implement the strategies identified in your plan.
- *Mobilize diverse participation*. OHE used an intensive participatory process to develop both the Statewide Plan and the CRDP Strategic Plan: it took approximately 5 years of supporting grassroots efforts, listening and incorporating stakeholders' input, and gaining the communities' trust.
- *Be transparent*. Transparency was vital as OHE and CDPH built meaningful and trusting relationships with unserved, underserved, and inappropriately served communities. Clear and regular communication, especially when there was "bad news" (eg, funding reduction or elimination or inability to implement all community recommendations), was crucial to maintaining trust.
- *Streamline administrative efforts*. Consolidating several different offices into the OHE led to several challenges, and it was critical to ensure that the goals of the defunct offices were integrated into OHE's work.
- *Utilize policy levers*. OHE was required to build formalized and transparent cross-sector partnerships with different organizations and communities per the California Health and Safety Code, a requirement that has been foundational for OHE's success in relationship building.
- *Prioritize time for community outreach and engagement*. To effectively engage with community stakeholders, plan for adequate staffing and sufficient staff time to allow staff, as state representatives, to listen to community concerns about what is working and where there are opportunities for improvement. By providing enough time and staffing, department leadership can stay well informed and make sound decisions on program design and implementation.

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